DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

February 11, 2016

Ms. Marie Zimmerman
Medicaid Director
Minnesota Department of Human Services
540 Cedar St, PO Box 64983
St. Paul, MN 55167-0983

Dear Ms. Zimmerman:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to extend Minnesota's section 1115 demonstration, Prepaid Medical Assistance Project Plus (PMAP+) (Project No. 11-W-00039/5). This approval is effective through December 31, 2020. This extension is granted under the authority of section 1115(a) of the Social Security Act. This five-year extension allows the state to continue:

- Medicaid coverage for one-year olds with incomes above 275 percent of the federal poverty level (FPL) and at or below 283 percent of the FPL;
- Waiver of requirements to redetermine the basis for eligibility for Medicaid Caretaker adults with incomes at or below 133 percent of the FPL living with child (ren) age 18 who are not full time secondary school students;
- Full Medical assistance benefits for pregnant women during their hospital presumptive eligibility period; and,
- Graduate Medical Education (GME) payments through the Medical Education and Research Costs (MERC) trust fund.

The demonstration no longer contains authority related to:

- American Indians, as defined in 25 U.S.C. 1603(c), who would not otherwise be mandatorily enrolled in managed care;
- Children under age 19 who are in state-subsidized foster care or other out-of-home placement; and
- Children under age 19 who are receiving foster care under title IV-E.

CMS's approval of the PMAP+ extension includes the following changes to the Special Terms and Conditions (STCs):

- Additional MERC evaluation and reporting requirements; and
- Deletion of the Comprehensive State Quality Strategy requirements.

CMS's approval of the PMAP+ extension is conditioned upon continued compliance with the enclosed special terms and conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The award is also subject to receipt of your written acknowledgement of the award and acceptance of the STCs within 30 days of the date of this letter.

Please send your written acceptance and any communications or official correspondence concerning the demonstration to your project officer, Ms. Dina Payne. Ms. Payne can be reached at (410) 786-3574, dina.payne1@cms.hhs.gov or at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Mailstop: S2-01-16
Baltimore, MD 21244-1850

Please send official communications regarding program matters simultaneously to Ms. Payne and to Ms. Ruth Hughes, Acting Associate Regional Administrator for the Division of Medicaid and Children's Health in our Chicago Regional Office. Ms. Hughes' contact information is:

Ms. Ruth Hughes
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations Program
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, State Demonstrations Group, Center for Medicaid & CHIP Services, at (410) 786-9535.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Vikki Wachino
Director

Enclosures

cc: Ruth Hughes, Associate Regional Administrator, CMS Region V

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITIES

NUMBER: **11-W-0039/5**

TITLE **Minnesota Prepaid Medical Assistance Project Plus (PMAP+)**

AWARDEE: **Minnesota Department of Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this demonstration, be regarded as expenditures under the state's Medicaid title XIX state plan.

Expenditure Authorities

Under the authority of section 1115(a)(2) of the Act, expenditures made by the state for the items identified below (which are not otherwise included as expenditures under section 1903) will be regarded as expenditures under the state's title XIX plan for the period of this extension.

The expenditure authorities listed below promote the objectives of title XIX by: increasing overall coverage of low-income individuals in the state, improving health outcomes for Medicaid and other low-income populations in the state, and increasing access to, stabilizing, and strengthening the availability of provider and provider networks to serve Medicaid and low-income individuals in the state.

The following expenditure authorities shall enable Minnesota to operate its section 1115 demonstration

1. Population 1: Expenditures for Medicaid coverage for children from ages 12 months through 23 months, who would not otherwise be eligible for Medicaid, with income above 275 percent and at or below 283 percent of the federal poverty level (FPL).

2. Expenditures for Medicaid coverage for pregnant women described in section 1902(a)(47) of the Act, to the extent that services are provided during a hospital presumptive eligibility period, that are in addition to ambulatory prenatal care services.

3. Expenditures for payments made directly to medical education institutions or medical providers and restricted for use to fund graduate medical education (GME) of the recipient institution or entity through the Medical Education and Research Costs (MERC) trust fund. In each demonstration year, payments made under this provision are limited to the amount claimed for federal financial participation (FFP) under this demonstration as MERC expenditures for state fiscal year (SFY) 2009. Except as specifically authorized in the STCs, the state may not include GME as a component of capitation rates or as the basis

for other direct payment under the State plan. This expenditure authority will be subject to changes in federal law or regulation that may restrict the availability of federal financial participation for GME expenditures.

Requirements Not Applicable to the Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the list below, shall apply to the expenditure authorities beginning as of January 1, 2016 through December 31, 2020.

1. Managed Care Payment	**Section 1903(m)(2)(A)(ii) Section 1902(a)(4)**

To the extent necessary to allow the state to make payments directly to providers, outside of the capitation rate, for GME and other medical education through the MERC trust fund.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITIES

NUMBER: **11-W-00039/5**

TITLE: **Minnesota Prepaid Medical Assistance Project Plus**

AWARDEE: **Minnesota Department of Human Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration project from January 1, 2016 through December 31, 2020.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are in effect to enable Minnesota to carry out the PMAP+ demonstration.

Title XIX Waivers

Redeterminations for Caretaker Adults Section 1902(a)(17)

To the extent necessary to enable the state to not perform a redetermination of the basis of eligibility for caretaker adults with income at or below 133 percent of FPL because they assume responsibility for and live with a child age 18 who is not a full time student in secondary school.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00039/5**

TITLE: **Minnesota Prepaid Medical Assistance Project Plus (PMAP+)**

AWARDEE: **Minnesota Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) section 1115(a) Medicaid demonstration extension (hereinafter "demonstration"). These STCs govern the operation of the PMAP+ demonstration by the Minnesota Department of Human Services (DHS), which has been approved by the Centers for Medicare & Medicaid Services (CMS). To facilitate the STCs set forth in detail the nature, character, extent of federal involvement in the demonstration, and the state's obligations to CMS during the life of the demonstration. The STCs are effective on the date of the approval letter unless otherwise specified. All previously approved STCs, Waivers, Expenditure Authorities and Not Applicables are superseded as of the date of approval. This demonstration extension is approved through December 31, 2020.

The STCs have been arranged into the following subject areas:

I. Preface;
II. Program Description and Objectives;
III. General Program Requirements;
IV. Eligibility and Demonstration Scope;
V. Benefits;
VI. Cost Sharing;
VII. Medical Education and Research Costs (MERC);
VIII. General Reporting Requirements;
IX. General Financial Requirements Under title XIX;
X. Monitoring Budget Neutrality;
XI. Evaluation of the Demonstration;
XII. Schedule of State Deliverables for the Demonstration Extension Period.

Attachment A Quarterly Report Content and Format
Attachment B. Evaluation Plan (future)
Attachment C Historical PMPM for the PMAP+ Demonstration

II. PROGRAM DESCRIPTION AND OBJECTIVES

Minnesota's section 1115 PMAP+ demonstration was initially approved and implemented in July 1995. Its original purpose was to enable the state to establish a prepaid, capitated managed care delivery model that operates statewide and to provide federal support for the extension of health care coverage to additional populations through the MinnesotaCare program. The demonstration has also been used to test waivers and expenditure authorities that allow the state to simplify and streamline Medicaid program administration, and for alternative funding and payment approaches to support graduate medical education (GME) through the Medical Education and Research Costs (MERC) fund.

In December 2013, Minnesota was granted a one-year temporary extension for PMAP+, with amendments to reflect new health care coverage options introduced in 2014 under the Affordable Care Act. The extended demonstration continued MinnesotaCare coverage only for 19 and 20 year olds, caretaker adults, and adults without children with incomes above 133 percent and at or below 200 percent of the federal poverty level (FPL), with the expectation that MinnesotaCare would eventually be transitioned to a Basic Health Plan (BHP) option for these groups in 2015. Other populations that participated in MinnesotaCare – pregnant women, children, foster care age outs, juvenile residential correctional facility post-release, and adults with incomes at or below 133 percent of the FPL – began receiving Medicaid coverage in 2014 under Minnesota's state plan, and MinnesotaCare adults with incomes above 200 percent of FPL were transitioned to subsidized qualified health plan coverage through Minnesota's new state-based Marketplace. Waiver and expenditure authorities allowing streamlining benefit sets for pregnant women, GME funding through MERC, medical assistance for children ages 12 through 23 months with incomes at or below 283 percent of FPL, and mandatory managed care for population groups were continued in the extended demonstration. New authority was granted to provide medical assistance for caretaker adults who live with and are responsible for children age 18 who are not full time secondary school students.

In December 2014, CMS approved a one year temporary extension of the PMAP+ demonstration, through December 31, 2015 to continue authorities for:

- coverage of children ages 12 through 23 months with incomes above 275 percent FPL and at or below 283 percent of the FPL;
- coverage of parents and caretaker adults with incomes at or below 133 percent of the FPL who assume responsibility for and live with an 18 year old who is not a full time secondary school student;
- pregnant women in need of full medical assistance benefits during their hospital presumptive eligibility period;
- mandatory enrollment into prepaid managed care of certain groups that are excluded from such under section 1932 of the Act; and
- GME payments through the MERC fund.

This 5-year extension of authorities, through December 31, 2020, contains all of the features of the temporary extension granted in December 2014, except that the authority related to mandatory enrollment into managed care was removed from the demonstration and the authority related to parents and caretaker relatives was changed from an expenditure to a waiver authority, since it became clear that there is no extension of eligibility, merely a change in eligibility redetermination practices.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid Program expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents, of which these terms and conditions are part, must apply to the demonstration, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs as needed to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STCs 6 and 7. CMS will notify the state within 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy.**

    a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

b) If mandated changes in the federal law, regulation, or policy requires state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit a title XIX state plan amendment for changes to any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the state plan is required, except as otherwise noted in these STCs. In all such instances, the Medicaid state plan governs.

6. **Changes Subject to the Demonstration Amendment Process.** Changes related to program design, eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, federal financial participation (FFP), sources of non-federal share of funding, budget neutrality, and other comparable program and budget elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act. The state must not implement changes or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. In certain instances, amendments to the Medicaid state plan may or may not require an amendment to the demonstration as well. Amendments to the demonstration are not retroactive and federal financial participation (FFP) will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with the STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in STC 7, required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must be accompanied by information that includes but is not limited to the following:

    a) Demonstration of Public Notice 42 CFR §431.408 and tribal consultation: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 and documentation that the tribal consultation requirements outlined in STC 15 have been met.

    b) Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment, including; what the state intends to demonstrate via the amendment as well as impact on beneficiaries with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming title XIX and/or title XXI state plan amendment, if necessary.

c) Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested for the amendment.

d) A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

e) An up-to-date CHIP allotment neutrality worksheet, if necessary; and

f) Updates to existing demonstration reporting, quality and evaluation plans: A description of how the evaluation design, comprehensive quality strategy and quarterly and annual reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 6 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 9. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.

9. **Demonstration Transition and Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements;

a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30- day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

b) The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

c) Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.

d) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hhearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category in accordance with 42 CFR §413.916.

e) Exemption from the Public Notice Procedures of 42 CFR §431.416(g): CMS may expedite federal and state public notice requirements in the event it determines that the objectives of titles XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).

f) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **Expiring Demonstration Authority.** For demonstration authority that expires prior to the overall demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a) Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b) Expiration Procedures: The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

c) Federal Public Notice: CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR § 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d) Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

11. **CMS Right to Amend, Terminate or Suspend.** CMS may amend, suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

13. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, the state public notice process for Section 1115 demonstrations at 42 C.F.R. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

    a) In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R.§431.408(b)(2)).

    b) In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC 27, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 28

17. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The state shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information on T-MSIS is available in the August 23, 2013 State Medicaid Director Letter.

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IV. ELIGIBILTY AND DEMONSTRATION SCOPE

18. **Eligibility.** Demonstration eligibles are described in the chart below:

Medicaid state plan populations required to enroll in managed care in order to receive benefits transitioned to the state's 1915(b) waiver authority effective January 1, 2016.

a) Expansion Groups Eligible Through the Demonstration

Population Number	**Population Description**	**Funding Stream**	**CMS-64 Eligibility Group**
Population 1	Infants age 12 months through 23 months (MA One Year Olds) with incomes above 275 percent FPL and at or below 283 percent FPL.	title XIX	MA Children Age 1

b) Other Groups Affected by the Demonstration

Medicaid Caretaker Adult. Medicaid Caretaker Adults with income at or below 133 percent of the FP living with child(ren) age 18 will not have the basis for their eligibility redetermined on the basis that the child(ren) are not full time secondary school students. The term "caretaker adult" includes parents and other caretaker relatives. Caretaker adults have incomes at or below 133 percent of the FPL The demonstration provides expenditure authority for Medicaid Caretaker adults who meet the income standards for Medical Assistance and live with and assume primary responsibility for child(ren) age 18 who are not enrolled full time in secondary school.

Pregnant Women in a Hospital Presumptive Eligibility Period. The demonstration provides Medicaid coverage for pregnant women described in section 1902(a)(47) of the Act, to the extent that services are provided during a hospital presumptive eligibility period, that are in addition to ambulatory prenatal care services.

V. BENEFITS

19. **Benefits Package: MA One Year Olds.** The benefit offered to MA One Year Olds is identical to the benefit offered to the Optional Targeted Low-Income Children's group in Minnesota's Medicaid state plan , including all services that meet the definition of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) found in section 1905(r) of the Act.

20. **Benefits Package: Pregnant Women.** The benefit for pregnant women during a

hospital presumptive eligibility period (as defined in section 1902(a)(47)(B)) will be the full medical assistance benefit that is available to qualified pregnant women (in accordance with section 1902(a)(10)(A)(i)(III) of the Act).

21. **Minimum Essential Coverage**. Section 5000A(f)(1)(E) of the Internal Revenue Code grants the Secretary of Health and Human Services, in coordination with the Secretary of Treasury, the authority to recognize otherwise non-specified health benefits coverage as minimum essential coverage (MEC) for the purposes of purposes of section 5000A of the Internal Revenue Code. In accordance with this authority, CMS will inform the state of its determination of whether we recognize the health benefits coverage provided under this demonstration as MEC.

VI. COST SHARING

22. **Cost Sharing in Medicaid.**

a) The cost sharing requirements for Medicaid eligibles under the Medicaid state plan must conform to the requirements set forth in the state plan.

b) The cost sharing requirements for MA One Year Olds must be identical to the requirements specified for Medicaid eligible infants, as specified in the Medicaid state plan.

c) The cost sharing requirements for pregnant women described in section 1902(a)(47) and MA Caretaker Adults with an 18 year old conform to the requirements set forth under the state plan for those populations, respectively.

d) **Co-Payments and Indians.** Items or services furnished to an Indian directly by Indian Health Services, an Indian Tribe or Tribal Organization or an Indian Urban Organization (I/T/U), or through referral under contract health services are exempt from copayments, coinsurance, deductibles, or similar charge.

VII. MEDICAL EDUCATION AND RESEARCH COSTS (MERC)

23. Medical Education and Research Costs (MERC) Trust Fund. Through expenditure authority granted under this demonstration, total computable payments that are paid directly to medical education institutions (or to medical care providers) through the MERC Trust Fund are eligible for FFP to the extent consistent with the following limitations:

a) Each demonstration year (DY), payments made under this provision are limited to the amount claimed for FFP under this demonstration as MERC expenditures for SFY 2009, and the distribution set forth in (c) below. This aggregate limit applies to all MERC payments authorized under this demonstration.

b) The state may not include GME as a component of capitation rates or as a direct payment under the state plan for managed care enrollees while this expenditure authority exists, with the exception of GME paid outside of MERC based on hospital services furnished to managed care enrollees through managed care products for which no carve- out existed in calendar year 2008, which includes the MinnesotaCare Program, the Minnesota Disability Health Options Program, and those capitation payments for dual eligibles enrolled in the Minnesota Senior Health Options Program. The state may also continue to make a GME adjustment to capitation rates paid to a health plan or a demonstration provider serving MA enrollees residing in Hennepin County in order to recognize higher than average GME costs associated with enrollees utilizing Hennepin County Medical Center, not to exceed $6,800,000 in annual total computable payments. The GME authorized to be paid outside of MERC and the adjustment to the health plan or demonstration provider rates is in addition to the MERC adjustment and is not subject to the MERC limit. Nothing in this provision exempts Minnesota from any of the requirements of 42 CFR 438.6(c) with respect to Medicaid managed care rate setting and actuarial soundness.

c) The amounts described in (a) may be distributed as follows:

i. Up to $2,157,000 may be paid to the University of Minnesota Board of Regents, to be used for the education and training of primary care physicians in rural areas, and efforts to increase the number of medical school graduates choosing careers in primary care;

ii. Up to $1,035,360 may be paid to Hennepin County Medical Center for graduate clinical medical education;

iii. Up to $1,121,640 may be used to fund payments to teaching institutions and clinical training sites for projects that increase dental access for under-served populations and promote innovative clinical training of dental professionals;

iv. Up to $17,400,000 may be paid to the University of Minnesota Academic Health Center for purposes of clinical GME;

v. Amounts in excess of those distributed under (i) through (iv) above, up to the prescribed limit, may be paid to eligible training sites, based on a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

vi. Public program revenue for the distribution formula includes revenue from medical assistance and prepaid medical assistance. Training sites that receive no public program revenue are ineligible for funds available under this subdivision.

Training sites whose training site level grant is less than $5,000, based on the formula described in this paragraph, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the formula described in this paragraph.,

d) FFP is available for total computable amounts paid from the MERC Trust Fund to recipient entities, within the limits described in this STC and the expenditure authorities. The Minnesota Department of Health, which operates the MERC Trust Fund, must certify the total computable payments made from the MERC Trust fund to eligible entities in order for the state to receive FFP.

e) The state shall provide information to CMS regarding any modifications to the existing source of non-federal share for any MERC or GME expenditures claimed under PMAP+. This information shall be provided to CMS, and is subject to CMS approval, prior to CMS providing FFP at the applicable federal matching rate for any valid PMAP+ expenditures.

f) As part of the annual report required under STC 28, the state must include a report on MERC and GME activities in the most recently completed DY, that must include (at a minimum):

i. A list of the sponsoring institutions and training sites receiving payments from the MERC trust fund under these provisions, the amount paid to each sponsoring institution/training site, the subparagraph of (c) above under which each payment was made, and the source of the non-federal share for each payment (i.e., each payment from the MERC trust fund must be identified with a corresponding transfer into the fund to account for the non-Federal share). A blanket statement can be used if the source of the non-federal share is the same for all or most of the payments. Sponsoring institutions are the entities that receive payments from the MERC Trust Fund under (c)(i) through (c)(iv) above. The amounts paid to sponsoring institutions, and by training sites under (c)(v), are the basis for Minnesota's claim of FFP.

ii. With respect to payments made under (c) above: a description of the percentage of medical residents whose training occurs in MERC-supported facilities, the number of providers in MERC eligible professions who are enrolled in Medicaid, the percentage of MERC trained physicians who remain in Minnesota to practice upon completing their MERC supported education, and the number and location of primary care providers who received MERC funded supported training.

iii. A description of the process used by the University of Minnesota Board of Regents to allocate funds they received from the MERC trust fund, a list of sub-grantees receiving these funds, and the amount each sub-grantee received;

iv. With respect to payments made under (c)(iii) above: (A) a description of the public process used to determine which potential sponsoring institutions will receive grants and the amount of each grant, and (B) if any of the sponsoring institutions made sub-grants, a list of the sub-grantees and the amount each received; and

v. With respect to payments made under (c)(v) above: a description of the public process used to determine which potential training site will receive grants and the amount of each grant.

vi. Any updates in MERC evaluation activities required under STC 47.

VIII. GENERAL REPORTING REQUIREMENTS

24. General Financial Requirements. The state must comply with all general financial requirements under title XIX of the Social Security Act in section X of the STCs.

25. Reporting Requirements Relating to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality as outlined in Section 42. The state must submit any corrected budget neutrality data upon request.

26. Monitoring Calls. The state must participate in monitoring calls with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to: updates on population transitions to other programs, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, MCO financial performance that is relevant to the demonstration, enrollment of all waiver and expenditure authority populations in the demonstration progress on evaluations, state legislative developments, , and any demonstration amendments, concept papers, or state plan amendments. CMS will update the state on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

27. Quarterly Progress Reports. The state must submit progress reports no later than 60 days following the end of each calendar quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include:

a) An updated budget neutrality monitoring spreadsheet;

b) Events occurring during the quarter, or anticipated to occur in the near future, that will effect health care delivery, including but not limited to: benefits; enrollment of all populations covered by waiver or expenditure authorities in the demonstration; grievances; quality of care; access; pertinent legislative activity; and other operational issues relevant to the demonstration.

c) Action plans for addressing any policy, administrative or budget issues identified;

d) Quarterly enrollment reports that include the member months for demonstration Population 1 and other groups affected by the demonstration; and,

e) Evaluation activities and any interim findings.

28. Annual Report. The state must submit a draft annual report documenting annual enrollment, benefits, grievances, quality of care and any access issues for all populations granted included in waiver or expenditure authority under the demonstration. The report must also document accomplishments, project status, quantitative and case study findings, any interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy, and administrative difficulties and solutions in the operation of the demonstration. The state must submit the draft annual report no later than 120 days after the close of each DY. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

a) As an attachment to the annual report, the state must submit the following information regarding the managed care plans the state contracts with to provide PMAP+ services.

i. A description of the managed care contract bidding process;

ii. The number of contract submissions, the names of the plans, and a summary of the financial information, including detailed information on administrative expenses, premium revenues, provider payments and reimbursement rates, contributions to reserves, service costs and utilization, and capitation rate-setting and risk adjustment methods submitted by each bidder;

iii. Annual managed care plan financial audit report summary;

iv. A description of any corrective action plans required of the managed care plans; and

v. A summary of any complaints received by the state from the public regarding the managed care contracting and oversight process.

29. Final Report. Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 90 days after receipt of CMS comments.

IX. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

This project is approved for title XIX and title XXI expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

30. Quarterly Expenditure Reports: CMS 64. The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. The state must reconcile expenditures for incarcerated beneficiaries on a quarterly basis, and make any necessary adjustments on the CMS-64 to ensure that no FFP was inadvertently claimed for incarcerated beneficiaries during the reporting quarter. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X.

31. Reporting Expenditures Under the Demonstration: CMS-64. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a) **Tracking Expenditures.** In order to track expenditures under this demonstration, Minnesota must report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the state Medicaid Manual (SMM). All demonstration expenditures subject to the budget neutrality expenditure limit will be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). DY 1 is defined as the year beginning July 1, 1995, and ending June 30, 1996, and DY 2 and subsequent DYs are defined accordingly. All other Medical Assistance payments that are not subject to the budget neutrality expenditure limit for PMAP+, and are not part of any other title XIX waiver program, should be reported on Forms CMS-64.9 Base and/or 64.9P Base as instructed in the SMM.

b) For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or l0C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the

State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 41.

c)For each DY, beginning in waiver year 8, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted reporting expenditures for the demonstration populations, by eligibility group. Payments made to provide health care services to the eligibility groups listed below are the expenditures subject to the budget neutrality expenditure limit. The state must complete separate pages for the following eligibility groups:

i. MA Children Age One. Population 1, waiver name: "MA CHILDREN AGE 1";

ii. **Medicaid Caretaker Adults with 18 Year Olds**. Population 2, waiver name: "MA CARETAKER 18 YR OLD."

d) The allocated expenditures for Caretaker Adults with 18 year olds (population 10) described in waiver form "MA CARETAKER 18 YR OLD" are estimates of the allocated costs. This method will result in a corresponding reduction in line 18A of the corresponding pages. The state will use the following formula to estimate allocated costs for this group: 0.83% * expenditures for MA Caretaker Adults = estimated allocated expenditures. Percentage is based on the percentage of MA Caretaker Adults with youngest or only child age 18 as compared to all MA Caretaker Adults.

e) For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for the EGs outlined in Section IV, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

f) **Premiums and Pharmacy Rebates.** Premiums that are collected by the state from enrollees whose expenditures are subject to budget neutrality must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. Pharmacy rebates are reported on Form CMS-64.9 base, Service Category Line 7. Neither premium collections nor pharmacy rebates figure into the calculation of net expenditures subject to the budget neutrality test.

g) **Payments for Health Plan Performance.** The state makes annual payments to recognize health plan performance of contractual targets during the previous calendar year. Such payments should be allocated on the CMS-64 waiver pages to reflect the amounts attributable to waiver group and waiver year in the following manner. First, determine the percentage distribution of each calendar year's payment amount by waiver year and waiver group. Then apply those same proportions to the payment totals for the same calendar year.

h) Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration using Forms

CMS-64.10 Waiver and/or 64.10P Waiver with waiver name "ADM".

i) **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

32. Reporting Member-Months: Quarterly Progress Report. For the purpose of calculating the budget neutrality expenditure limit, the state will provide to CMS on a quarterly basis the actual number of eligible member/months for each of the two eligibility groups (EGs) defined in (b) below. The enrollment data will be submitted to the CMS Project Officer 60 days after the end of each quarter as part of the quarterly progress report. To permit full recognition of "in-process" eligibility, reported counts of member months shall be subject to minor revisions as needed.

a) The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

b) Member months must be provided for the following eligibility groups:

i. **MA Children Age One** (waiver name: "MA CHILDREN AGE 1");
ii. **Medicaid Caretaker Adults with 18 Year Olds** (Effective January 1, includes Population 2, Medicaid Caretaker Adults with 18 Yr Old) (waiver name "MA CARETAKER 18 YR OLD

33. Standard Medicaid Funding Process: CMS-37. The standard Medicaid funding process will be used during the demonstration. The state must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). The CMS will make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant

award to the state.

34. Medical Education and Research Costs (MERC). Claims eligible for FFP, based on payments from the MERC Trust Fund as described in STC 23, must be reported on separate Forms CMS-64.9 Waiver and 64.9 Waiver, on line 1D, using waiver name, "MERC 1115." These expenditures are not subject to the budget neutrality expenditure limit.

35. Extent of Federal Financial Participation for the demonstration. CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Section IX.

a) Administrative cost, including those associated with the administration of the PMAP+ demonstration;

b) Net expenditures of the Medicaid program that are paid in accordance with the approved state plan and waivers granted for the purpose of implementing PMAP+ ; and

c) Net expenditures that are paid in accordance with the approved expenditure authorities granted for the purpose of implementing PMAP+.

36. Sources of Non-Federal Share. The state certifies that the source of the non-Federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with title XIX of the Social Security Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a) CMS shall review the sources of the non-Federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b) The state shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.

c) Additionally, the state shall provide information to CMS regarding any modifications to the existing source of non-Federal share for expenditures claimed under PMAP+. This information shall be provided to CMS, and is subject to CMS approval, prior to CMS providing FFP at the applicable Federal matching rate for any valid PMAP+ expenditures.

d) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover,

no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid or demonstration payments. This confirmation of Medicaid and demonstration payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid or the demonstration and in which there is no connection to Medicaid or demonstration payments) are not considered returning and/or redirecting a Medicaid or demonstration payment.

37. State Certification of Funding Conditions. The state certifies that the following conditions for non-Federal share of demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been used as the non-Federal share of title XIX payments.

b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration, governmental entities must certify to the state the total computable amount of demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for Federal match.

d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state in accordance with title XIX of the Social Security Act and implementing regulations. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Additionally, all transfers must occur prior to the specific payments under the demonstration which the transfers are designated to fund. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid or demonstration payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid or the demonstration and in which there is no connection to Medicaid or

demonstration payments, are not considered returning and/or redirecting a Medicaid or demonstration payment.

e) Nothing in these STCs concerning certification of public expenditures relieves the state of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

38. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

39. Program Integrity. The state must have processes in place to ensure that there is no duplication of Federal funding for any aspect of the demonstration.

X. MONITORING BUDGET NEUTRALITY

40. Limit on Title XlX Funding. The state will be subject to a limit on the amount of Federal title XIX funding that the state may receive on expenditures for the eligibility groups listed in STC 32(b) during the demonstration period. This limit will be determined using a per capita cost method. In this way, the state will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the state at risk for changing economic conditions. However, by placing the state at risk for the per capita costs of Medicaid eligibles, CMS assures that the state demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. All eligibility groups listed in STC 18(a) are hypothetical groups, meaning that they are groups of individuals that could have been covered under the Medicaid state plan, but instead are covered solely through the demonstration. CMS policy prohibits the use of any savings from hypothetical groups (i.e., any variance between the projected and actual coverage costs) to offset costs arising from other demonstration expenditure authorities (other than the costs of the hypothetical groups themselves). Costs for Medicaid state plan populations affected by the demonstration and MERC are not subject to a budget neutrality test.

41. Projecting Service Expenditures. Each DY estimate of Medicaid service expenditures will be calculated as the product of the projected per member/per month (PMPM) cost times the actual number of eligible member months for the eligibility groups listed in STC 32(b) as reported to CMS by the state under the guidelines set forth in Section X, STC 32. The budget neutrality expenditure limit for the eligibility groups listed in STC 32 (b) is the sum of these annual limits for all DYs.

42. Calculation of the Budget Neutrality Expenditure Limit. The following are the PMPM costs for the calculation of the budget neutrality expenditure limit for the demonstration enrollees in the eligibility groups listed in paragraph 32(b) under this extension period. *The DY for purposes of budget neutrality is July 1 through June 30.*

Eligibility Group	Trend Rate	DY 21 SFY 2016 PMPM	DY 22 SFY 2017 PMPM	DY 23 SFY 2018 PMPM	DY 24 SFY 2019 PMPM	DY 25 SFY 2020 PMPM	DY 26 SFY 2021 PMPM
MA Children Age One	3.9 %	$389.10	$404.27	$420.04	$436.42	$453.44	$471.13
Medicaid Caretaker adults living with 18 year old	4.8%	$537.94	$563.76	$590.82	$619.18	$648.90	$680.05

***** Historical PMPM limits for DY 1 (1996) through DY 21 (2015) are provided in Attachment C.

43. Application of the Budget Neutrality Test. The budget neutrality limit for the eligibility groups listed in STC 32(b) shall consist of a comparison between the federal share of the budget neutrality expenditure limit for the demonstration and the amount of FFP that the state has received for expenditures subject to that limit.

a) The federal share of the budget neutrality expenditure limit for the eligibility groups listed in STC 32 (b) is equal to the budget neutrality limit for the demonstration multiplied by the Composite Federal Share.

b) The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C, by total computable expenditures as reported for the same period on the same schedule. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative method based on mutual agreement.

44. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's cumulative expenditures exceed the calculated budget neutrality expenditure limit by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan for CMS for approval

Demonstration Year	Cumulative Expenditure Limit Definition	Percentage
Year 1 through 26	Combined budget neutrality expenditure caps plus	0 percent

45. Exceeding Budget Neutrality. If, at the end of this demonstration period, the budget neutrality expenditure limit for the demonstration has been exceeded, the excess Federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XI. EVALUATION OF THE DEMONSTRATION

46. Submission of Draft Evaluation Design. The state must submit to CMS for approval a draft evaluation design for a revised evaluation of the demonstration incorporating changes for 2016, within 120 days after CMS' approval of the demonstration extension. The design submitted under this STC may be in the form of an addendum to the draft evaluation plan already submitted by Minnesota to CMS for the 2015 approval period. At a minimum, the draft design must include a discussion of the goals and objectives set forth in section II of these STCs, as well as the specific hypotheses that are being tested, including those indicators that focus specifically on the target populations and all expenditure authorities as well as the public health outcomes, any administrative savings generated from the use of demonstration funds and the effectiveness of the demonstration on all populations and graduate medical education funds affected by the demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state.

47. Further Extension of Demonstration. In the event the state requests to extend the demonstration beyond the current approval period, the state must submit with its application a draft evaluation design for an overall evaluation of the demonstration. The draft design must cover every element of the demonstration that the state proposes to continue past December 31, 2020. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation. (CMS prefers that an outside contractor be used, to the extent feasible.)

The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. Among the characteristics of rigor that will be met are the use of best available data, investigation design, and discussion on comparison groups for each testable hypothesis, reporting of the limitations of data and their effects on results; and the generalizability of results to the waiver population. Information from the EQRO may be considered for the purposes of evaluation, as appropriate. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including

standards for the evaluation design, conduct, interpretation, and reporting of findings.

The design must include a proposed budget that is adequate to support the scale and rigor consistent with the expectations discussed herein. The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including a description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable), the measure steward, the baseline value for each measure, and the sampling methodology for assessing these outcomes. CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).

The evaluation design must also discuss the data sources used, including, but not limited to, the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

The evaluation design must also discuss the impact of the alternative funding and payment approaches to support graduate medical education through the MERC fund including, but not limited to the following:

- How the recipients of MERC funds used the payments;
- The number of graduate medical training slots that are supported through MERC;
- The impact of MERC funds on the number of providers available to serve the needs of the Medicaid eligible population;
- How the number of primary providers increased in rural Minnesota as compared to providers in urban counties; and
- The advantage of distributing payment from a medical education trust fund compared to making GME subsidy payments directly to providers.

48. Final Evaluation Design and Implementation. CMS must provide comments on the draft evaluation design described in STC 46 within 60 days of receipt, and the state must submit a final design within 60 days after receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the final evaluation report within 120 days after the expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final

evaluation report within 60 days after receipt of CMS comments. The final evaluation report must include the following: an executive summary; a description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions; a summary of the evaluation design employed, including research questions, hypotheses, study design (qualitative versus quantitative or both), performance measures, data sources, and analyses; a description of the population included in the evaluation (by age, gender, race/ethnicity, etc.); and final evaluation findings, including a discussion of the findings (interpretation and policy context); successes, challenges, lessons learned, and policy implications.

49. Cooperation with CMS Evaluators. Should CMS conduct an independent evaluation of any component of the demonstration the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS as requested.

50. Public Access. The state shall post the final approved Evaluation Design on the state Medicaid website within 30 days of approval by CMS.

51. Electronic Submission of Reports. The state shall submit all required plans and reports using the process stipulated by CMS, if applicable**.**

XII. SCHEDULE OF STATE DELIVERABLES DURING THE TERM OF THIS DEMONSTRATION EXTENSION

The state is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date - Specific	Deliverable	STC Reference
Within six months of demonstration implementation and annually thereafter	Post Award Forum	Section III, STC 16
60 days following the end of the quarter	Quarterly Operational, Progress and Enrollment Reports	Section VIII STC 27
120 days following the end of the	Annual Report	Section VIII STC 28
60 days following the end of the quarter	CMS-64 Reports	Section IX, STC 31
60 days following the end of the quarter	Eligible Member Months	Section IX, STC 32

30 days following the end of the quarter	Quarterly Financial Reports	Section IX, STC 30
120 days following approval of the	Draft Evaluation Design	Section XI, STC 46
Within 60 days of receipt of CMS comments	Final Evaluation Design	Section XI, STC 48
120 days following the end of the demonstration period	Draft Final Evaluation Report	Section XI, STC 48
Within 90 days of receipt of CMS comments	Final Evaluation Report	Section XI, STC 48

ATTACHMENT A

Quarterly Report Content and Format

Under Section IX, STC 30, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – PMAP+
Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 1 (date of approval letter – 12/31/2017)
Federal Fiscal Quarter: 2/2015(1/15 - 3/15)

Introduction
Information describing the goals of the demonstration, what it does, and key dates of approval and operation. (This should be the same for each report.)

Enrollment Information
Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

Note: Member months for Medicaid Caretaker Adults shall be derived consistently with the formula set out at STC 31 (d).

Demonstration Populations (as hard coded in the CMS 64)	**Enrollees at close of quarter** (date)	**Current Enrollees** (to date)	**Disenrolled in Current Quarter**
Population 1: MA One Year Olds			
Medicaid caretaker adults who assume responsibility for and live with a child age 18 who is not a full time student in secondary school.			

Outreach/Innovative Activities
Summarize marketing, outreach, or advocacy activities to current and potential enrollees and/or promising practices for the current quarter.

Operational Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, approval and contracting with new plans; benefits; enrollment; grievances; quality of care; changes in provider qualification standards; access; proposed changes to payment rates; health plan financial performance that is relevant to the demonstration; LTSS implementation and operation; pertinent legislative activity; and other operational issues.

Policy Developments/Issues
Identify all significant policy and legislative developments/issues/problems that have occurred in the current quarter. Include updates on any state health care reform activities to coordinate the transition of coverage through the Affordable Care Act.

Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state's actions to address any issues.

Member Month Reporting
Enter the member months for each of the EGs for the quarter, for use in budget neutrality calculations.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Population 1: MA One Year Olds				
Medicaid caretaker adults who assume responsibility for and live with a child age 18 who is not a full time student in secondary school.				

Consumer Issues
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity in current quarter. The state must also report on the implementation and effectiveness of the Comprehensive Quality Strategy as it impacts the demonstration.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B. EVALUATION PLAN
(Approved August 9, 2017)

Prepaid Medical Assistance Project Plus (PMAP+)
Evaluation Plan 2015 to 2020

The PMAP+ Section 1115 Waiver has been in place for the last 20 years, primarily as the federal authority for the MinnesotaCare program, which provided comprehensive health care through Medicaid funding for people with income in excess of the standards in the Medical Assistance Program. The Department of Human Services (DHS) secured approval for BHP funding to run the MinnesotaCare program effective January 1, 2015. Even though the PMAP+ waiver is no longer necessary to continue the MinnesotaCare program, several aspects of the PMAP+ waiver continue to be necessary.

PMAP+ Section 1115 Waiver Extension January 1, 2015 through December 31, 2015

In December 2014, a one-year extension was granted for PMAP+, for the period of January 1, 2015 through December 31, 2015. The 2015 demonstration continues to provide important authorities for Minnesota's Medicaid program such as preserving eligibility methods currently in use for children ages 12 months through 23 months, simplifying the definition of a parent or caretaker relative to include people living with children under age 19, providing full Medical Assistance (MA) benefits for pregnant women during the period of presumptive eligibility, allowing mandatory enrollment of certain populations in managed care, and authorization of medical education funding.

PMAP+ Section 1115 Waiver Renewal January 1, 2016 through December 31, 2020

On June 30, 2015 DHS submitted a request to renew the PMAP+ waiver for the time period beginning January 1, 2016, and ending December 31, 2020. The proposed waiver extension seeks to continue federal authority for the following:

- Preserving eligibility methods currently in use for children ages 12 months through 23 months;
- Simplifying the definition of a parent or caretaker relative to include people caring for children under age 19;
- Providing full MA benefits for pregnant women during the period of presumptive eligibility; and
- Payments for graduate medical education costs through the Medical Education and Research Costs (MERC) fund.

Waiver Populations and Expenditure Authorities for PMAP+ 2015-2020 Evaluation

MA One-Year-Olds

The PMAP+ waiver provides expenditure authority for Medicaid coverage for children from age 12 months through 23 months, who would not otherwise be eligible for Medicaid, with incomes above 275% and at or below 283% of the federal poverty level (FPL).

Caretaker Adults with 18-Year-Old

The PMAP+ waiver provides expenditure authority for Medicaid coverage for Caretaker Adults who live with and assume responsibility for a youngest or only child who is age 18 and is not enrolled full time in secondary school. PMAP+ waiver authority allows Minnesota to waive the requirement to track the full-time student status of children age 18 living with a caretaker.
Beginning in 2014, Minnesota covers both adults without children and caretaker adults to 133% of the FPL under the state plan. Adults without children and caretaker adults are eligible for the full MA benefit set. Without waiver authority, a caretaker adult with a youngest child or only child turning 18 would need to be re-determined under an "adult without children" basis of eligibility. This exercise is meaningless because Minnesota covers adults and parents to the same income level. Health care coverage and cost sharing are the same.

The household size for the parent is independent of the required tracking of the child's full-time student status. For non-tax filing families, Minnesota has chosen age 19 as the age at which a child is no longer in the household. In a tax filing household, the parent's household size would depend on whether they expect to claim the child as a dependent, regardless of age. By waiving the requirement to track the full-time student status, Minnesota avoids requesting private data that will not be consequential to the consumer's eligibility for health care. In addition to relieving the burden on consumers and not requesting personal information that is not relevant to eligibility, coverage, or cost-sharing, Minnesota expects the waiver to result in administrative efficiency by simplifying the procedures that case workers need to follow.

Medical Education and Research Costs (MERC)

Through expenditure authority granted under the PMAP+ waiver, payments made through the Medical Education and Research Costs (MERC) Trust Fund through sponsoring institutions to medical care providers are eligible for federal financial participation.

Pregnant Women

The Patient Protection and Affordable Care Act (ACA) established the hospital presumptive eligibility (PE) program effective January 2014 allowing qualified hospitals to make MA eligibility determinations for people who meet basic criteria. Under hospital PE, covered benefits for pregnant women during a presumptive eligibility period are limited to ambulatory prenatal care. Minnesota has secured PMAP+ waiver authority to allow pregnant women to receive services during a presumptive eligibility period that are in addition to ambulatory prenatal care services. The benefit for pregnant women during a hospital presumptive eligibility period will be the full benefit set that is available to qualified pregnant women in accordance with section 1902(a)(10)(i)(III) of the Act. Implementation of presumptive eligibility began in July 2014.

Hypotheses, Research Questions and Evaluation Metrics

MA One-Year-Olds

Goal/Objective

The goal of the demonstration is to ensure at least comparable access and quality of preventive care to the MA one-year-old child population as compared to other children enrolled in public health care programs.

Research Question

- Did the MA one-year-old child population experience comparable utilization of services (i.e. childhood immunization status, well-child visits, and access to primary care practitioners) when compared to national Medicaid averages?
- Do the rates for each of the measures vary by race within Minnesota's MA one-year-old child population?

Hypothesis

- Providing health care coverage to the MA one-year-old child population, will result in access and quality of care for this population that is comparable to children enrolled in other public programs.

Research Question(s)	Comparison Population(s)	Measures	Comparison Years	Data Source(s)
1. Did the MA one-year-old child population experience comparable utilization of preventative and chronic disease services, when compared to national Medicaid averages?	Children 12-24 months who are enrolled in Medicaid in the United States.	a) Childhood immunization status (2 yrs.) (CIS)* b) Well-child visits (first 15 months) (W15)* c) Child access to primary care practitioners (ages 12-24 mos.) (CAP)*	MY 2016-2020 RY 2014-2015	MMIS claims data and national Medicaid NCQA Quality Compass rates national Medicaid data
2. Do childhood immunization status, well-child visits, or access to primary care practitioners vary by race within the one-year-old child population?	Comparisons by race will be made within the population of MA enrollees who are between 12 and 24 months of age.	a) Childhood immunization status (2 yrs.) (CIS)* b) Well-child visits (first 15 months) (W15)* c) Child access to primary care practitioners	MY 2016-2020 RY 2014-2015	MMIS claims data

Research Question(s)	Comparison Population(s)	Measures	Comparison Years	Data Source(s)
		(ages 12-24 mo.s) (CAP)*		
*NCQA HEDIS Measures				

Statistical Methods

The evaluation will use selected HEDIS performance measures to evaluate care for the MA one-year-old child population compared to other children enrolled in public health care programs. A comparison and stratification of the selected HEDIS and other performance measures will be made between the MA one-year-old population and the Medicaid national child (12 months-24 months) population to show the ongoing improvement in care for children enrolled in Medicaid in Minnesota. The HEDIS performance measures are rates that are generally defined as the sum of eligible individuals who received a service (numerator) divided by the total number of individuals who qualified for the service (denominator).

To address the first research question, each of the state's three overall HEDIS rates, along with the full collection of national rates, will be used to generate a percentile rank that will assess how well the state performed in these three areas relative to the other states in the nation.

For the second analysis, the individual-level state data will be stratified by race (Asian-Pacific Islander, Black, Hispanic, Native American, and White) and three separate tests for equality of proportions (one test per HEDIS rate), will be used to detect whether or not race influences quality and or access to care, as measured by the HEDIS rates. Medicaid Caretaker Adults with 18-Year Old.

Goal/Objective

The goal of the demonstration is to ensure at least comparable access and quality of prevention and chronic disease care for MA caretaker adults with an 18-year old child as compared to other adults who are enrolled in public health care programs.

Research Questions

- Did the MA caretaker adult waiver population in Minnesota experience comparable utilization of preventative and chronic disease care services for adults when compared to other adults who are enrolled in MA in Minnesota (i.e. annual dental visit, cervical cancer screening, comprehensive diabetes care, follow-up after hospitalization for mental illness, medication management for people with asthma, and access preventative/ambulatory health services)?
- Did the MA caretaker adult waiver population in Minnesota experience comparable utilization of preventative and chronic disease care services for adults when compared to

national Medicaid averages (i.e. annual dental visit, cervical cancer screening, comprehensive diabetes care, follow-up after hospitalization for mental illness, medication management for people with asthma, and access preventative/ambulatory health services)?

Hypothesis

Providing health care coverage to this adult caretaker waiver population will result in access and quality of prevention and chronic disease care for this population that is comparable to other adults enrolled in public health care programs.

Research Question(s)	Comparison Population(s)	Measures	Measurement Years (MY)/ Reference Years (RY)	Data Source(s)
1. Did the MA caretaker adult waiver population experience comparable utilization of preventative and chronic disease care services for adults when compared to other adults who are enrolled in MA in Minnesota?	a) MA parents in Minnesota b) MA adults without children in Minnesota	For both comparison populations, the following measures will be used: a) Annual dental visit b) Cervical cancer screening c) Comprehensive diabetes care d) Follow-up after hospitalization for mental illness e) Medication management for people with asthma f) Access preventative/ambulatory health services	MY 2016-2020 RY 2014-2015	MMIS claims data
2. Did the MA caretaker adult waiver population experience comparable utilization of preventative and chronic disease care services for adults when compared to national Medicaid averages (i.e. annual dental visit, cervical cancer screening, comprehensive diabetes care, follow-up after	a) Other adults enrolled in MA in the United States	a) Cervical cancer screening b) Comprehensive diabetes care c) Follow-up after hospitalization for mental illness d) Medication management for people with asthma e) Access preventative/ambulatory health services	MY 2016-2020 RY 2014-2015	MMIS claims data and national Medicaid NCQA Quality Compass rates national Medicaid data

Research Question(s)	Comparison Population(s)	Measures	Measurement Years (MY)/ Reference Years (RY)	Data Source(s)
hospitalization for mental illness, medication management for people with asthma, and access preventative/ambulatory health services)?				

Statistical Methods

The evaluation will use selected HEDIS performance measures to evaluate care for the MA caretaker adult waiver population compared to other adults enrolled in public health care programs. A comparison and race stratification of the selected HEDIS and other performance measures will be made between the waiver population and separate populations (i.e. other adults enrolled in MA in Minnesota to show the ongoing improvement in care for MA caretaker adults in Minnesota.

Since the populations of interest are completely independent, a series of tests for equality of proportions will be used to gauge the quality of care received by caretakers with children in MN and caretakers without children in MN.

To address the second research question, each of the state's five overall HEDIS rates, along with the full collection of national rates, will be used to generate a percentile rank that will assess how well the state performed in these five areas relative to the other states in the nation.

5.3 Medical Education and Research Costs (MERC) Trust Fund

Goal/Objective

There is an on-going need to support training opportunities for medical education in Minnesota. For nearly two decades, Minnesota has taken a unique approach to this issue through its section 1115 waiver authority under PMAP+. This authority is necessary to continue a grant payment structure for facilities accepting trainees to support the care of the Medicaid population. Without this grant program, many facilities, especially in rural areas, may not be able to participate in training activities for medical education, which help attract new providers ready to serve low-income and underserved areas of the state.

Through Minnesota's PMAP+ waiver, the MERC program supports the objectives of the Medicaid program by strengthening the state's provider network through residency grants to facilities serving the Medicaid population that accept trainees who will support patient care. This program also serves a variety of health professions, including training for professions where shortages exist for the

Medicaid population. The amount of the grant available to the facility is relative to their Medicaid-patient volume, providing an incentive for these facilities to serve a higher volume of the Medicaid population.

The key advantage of this approach is that MERC allows for a broader set of facilities to participate than just teaching hospitals, helping the state reach a larger portion of the state. Under the traditional fee-for-service system, medical education payments to teaching facilities are higher than those to non-teaching facilities. This is done in an effort to offset a portion of the higher costs faced by facilities that provide clinical medical education.

Hypothesis A

Providing a dedicated trust fund for graduate medical education will maintain or increase training opportunities at facilities statewide to support the care of the Medicaid population in Minnesota.

Research Questions

1. Were the number of students and residents at clinical training sites receiving MERC grant funds maintained or increased during this waiver period compared to the previous waiver period for rural and urban areas of the state?
2. How did the MERC fund grantees use the payments?

Hypothesis A

Research Question(s)	Comparison Population(s)	Measures	Comparison Years[1]	Data Source(s)
1. Were the number of students and residents at training sites maintained or increased during this waiver period compared to the previous waiver period for rural and urban areas of the state?[2]	a. **Rural:** Number of students and residents at training sites in rural areas of the state for Demonstration Year (DY) 19[3] and DY 20[4]. b. **Urban:** Number of students or residents at training sites in urban areas of the state for DY 19 and DY 20.	a. **Rural**: Compare the number of students and residents at training sites in rural Minnesota for years 2016 through 2020 to the number of students and residents at training sites in rural Minnesota for DY 19 and DY 20. b. **Urban**: Compare the number of students and	MY 2016-2020 RY 2014- 2015	MERC Program data

[1] Comparison Years are based on State Fiscal Years.
[2] Urban areas of the state include the seven-county metro area which includes the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Washington and Scott. The rural areas of the state include the remaining 80 counties in Minnesota.
[3] PMAP demonstration year 19 covers the period of July 1, 2013 through June 30, 2014.
[4] PMAP demonstration year 20 covers the period of July 1, 2014 through June 30, 2015.

Research Question(s)	Comparison Population(s)	Measures	Comparison Years[1]	Data Source(s)
		residents at training sites in urban areas of the state for the current waiver period to the number of students and residents at training sites in urban areas of the state in DY 19 and DY 20.		
2. How did the MERC-funded grantees use the payments?	N/A	Of the total grant distribution for years 2016 through 2020, identify the percentage of funds that were used to support training in the following health professions: a. Medical training (physicians) b. Dental providers (including dental therapists) c. Psychologists d. Pharmacists e. Community Paramedics f. Other health professionals	MY 2016-2020	MERC Program Data

Hypothesis B

Providing a dedicated trust fund for graduate medical education will support training activities which help to maintain or increase the number of primary care providers serving the Medicaid population in Minnesota.

Research Question

1. Was the ratio of primary care providers in rural Minnesota to primary care providers in urban Minnesota maintained or improved during this waiver period compared to the previous waiver period?
2. Was the ratio of rural primary care providers per 10,000 rural beneficiaries maintained or improved during this waiver period compared to the previous waiver period?
3. Was the ratio of urban primary care providers per 10,000 urban beneficiaries maintained or improved during this waiver period compared to the previous waiver period?

Hypothesis B

Research Question(s)	Comparison Population(s)	Measures	Comparison Years[1]	Data Source(s)
1. Was the ratio of rural, primary care providers to urban primary care providers maintained or improved during this waiver period compared to the previous waiver period?	Primary care providers in rural areas of the state in DY 19 and DY 20 who were enrolled in Medical Assistance. Primary care providers in urban areas of the state in DY 19 and DY 20 who were enrolled in Medical Assistance	For Medicaid enrolled providers only, compare the ratio of rural primary care providers to urban primary care providers for years 2016 through 2020 to the ratio of rural primary care providers to urban primary care providers for DY 19 and DY 20	MY 2016-2020 RY 2014- 2015	Medicaid Provider Enrollment Data for primary care providers.
2. Was the ratio of rural primary care providers per 10,000 rural beneficiaries maintained or improved during this waiver period compared to the previous waiver period?	Primary care providers per 10,000 beneficiaries in rural areas of the state in DY 19 and DY 20 who were enrolled in Medical Assistance.	For Medicaid enrolled providers only, compare the ratio of rural primary care providers per 10,000 rural beneficiaries for the years 2016 through 2020 to the ratio of rural primary care providers per 10,000 rural beneficiaries for DY 19 and DY 20	MY 2016-2020 RY 2014- 2015	Medicaid Provider Enrollment Data for primary care providers.
3. Was the ratio of urban primary care providers per 10,000 urban beneficiaries maintained or improved during this waiver period compared to the previous waiver period?	Primary care providers per 10,000 beneficiaries in urban areas of the state in DY 19 and DY 20 who were enrolled in Medical Assistance.	For Medicaid enrolled providers only, compare the ratio of urban primary care providers per 10,000 urban beneficiaries for the years 2016 through 2020 to the ratio of urban primary care per 10,000 urban beneficiaries for DY 19 and DY 20	MY 2016-2020 RY 2014- 2015	Medicaid Provider Enrollment Data for primary care providers.

[1] Comparison Years are based on State Fiscal Years.

Statistical Methods

The evaluation will use MERC program data to compare the annual number of students and residents at training sites in rural and urban areas of the state across the two waiver periods using chi-square tests for independence. The test will determine whether or not the number of students and residents change significantly over time or if they remain relatively constant. Grant fund distributions will be analyzed to determine utilization rates across health professions. Tests for equality of proportions will be used to assess whether or not the proportion of funds allocated to the program changed over time. The evaluation will use two equality of proportions tests to determine if the proportion of providers in rural and urban areas changed over time. Ratios between providers in rural in urban areas will also be compared using chi square tests. Additional analysis will evaluate provider to beneficiary ratios within geographical regions of the state to determine if MERC has impacted ratios between the two waiver periods.

5.4 Pregnant Women in a Presumptive Eligibility Period

Goal/Objective

The goal of the demonstration is to ensure at least comparable access and quality of prenatal and postpartum care to pregnant women enrolled in MA through the PMAP+ waiver authority as compared to national Medicaid averages.

Research Question

- Did the MA pregnant women waiver population experience comparable utilization of prenatal and postpartum care when compared to national Medicaid averages (i.e. prenatal visit within first trimester (or within 42 days of enrollment into MA) and postpartum visit between 21 and 56 days after delivery)?

Research Question(s)	Comparison Population(s)	Measures	Measurement Years (MY)/ Reference Years (RY)	Data Source(s)
1. Did the MA pregnant women waiver population experience comparable utilization of prenatal and postpartum care when compared to national Medicaid averages?	Pregnant women who are enrolled in Medicaid in the United States.	a) Prenatal visit within first trimester b) Postpartum visit between 21 and 56 days after delivery	MY 2016-2020 RY 2014-2015	MMIS claims data and national Medicaid NCQA Quality Compass rates national Medicaid data

Statistical Methods

The evaluation will use selected HEDIS performance measures to evaluate care for the waiver population compared to national averages. A comparison and stratification of the selected HEDIS and other performance measures will be made between the waiver population and national Medicaid averages for pregnant women to show the ongoing improvement in care for pregnant women enrolled in MA in Minnesota. Minnesota Managed Care HEDIS Hybrid data will also be utilized to determine differences in administrative versus hybrid rates for this measure.

Each of the state's two overall HEDIS rates, along with the full collection of national rates, will be used to generate a percentile rank that will assess how well the state performed in these two areas relative to the other states in the nation.

Qualifications of Staff Conducting Evaluation

The qualifications of the staff conducting the evaluation include but are not limited to the following key personnel.

Kevan Edwards has been with DHS for nearly two years and is currently the Research Director of Health Care Research and Quality Division/Research and Data Analysis Section. Dr. Edwards has a Ph.D. in Sociology, Health Services Research Supporting area from the University of Minnesota. Prior to his work at DHS, he was the Research Director, Health Economics Program at the Minnesota Department of Health working with the All Payer Claims Database. Areas of expertise include risk adjustment of cost and quality measures, and disparities in health status, health access, and health care utilization.

Barbara Frank, a Research Supervisor in the Research and Data Analysis section, has twenty years of experience using health care claims data (Commercial/Medicare/Medicaid) including four years of experience in HEDIS reporting. Ms. Frank has over 15 years of SAS experience, primarily using SAS Base/EG with DHS data. She has a Masters of Public Health. Prior to coming to DHS, Ms. Frank was the Director of Assistance, and Director of Workshops, Outreach and Research for the CMS Contract Research Data Assistance Center (ResDAC).

James Kuiper, Agency Policy Specialist, has been with the DHS Research and Data Analysis team since 2014. He has twenty-eight years of SAS Base/Stat/Macro programming in a variety of health care research settings (DHS warehouse, commercial health plans, and disease management) and is experienced in database programming in MS SQL Server, Access, and Proc SQL. Mr. Kuiper holds a Bachelor of Science in Mathematics and Statistics.

Monica Patrin, Agency Policy Specialist, has been with DHS since December 2016. After graduating from the University of Minnesota with a Masters in Statistics in 2013, she worked in education research and assessment as a data analyst/R programmer for almost three years. She has experience working with a variety of models used as the basis for teacher evaluations—(random effects models, error in variables models, multinomial logistic regression models, etc.).

Diane Reger, State Program Administrator – Principal, has been with MDH since 2000. She has administered the MERC grant program for sixteen years. Prior to coming to MDH, she worked in the insurance industry for ten years, in underwriting and sales and marketing analysis.

Mark Schoenbaum, MSW, is Director of Minnesota's Office of Rural Health and Primary Care at the Department of Health. He has over 35 years of state government experience in program management, policy analysis and evaluation. He manages a portfolio of state health care workforce development and safety net programs that includes the MERC program.

Evaluation Implementation Strategy and Timeline

Waiver Populations under Sections 5.1, 5.2, and 5.4

Beginning in 2021, performance measurement data will be extracted from DHS' managed care encounter and fee-for-service database to allow for a sufficient encounter/claim run-out period. Performance measurement rates for the baseline period (CY 2014 and 2015) will be calculated for the targeted populations and compared to CY 2016, 2017, 2018, 2019, and 2020. In addition, national benchmarks will be obtained from NCQA's Medicaid Quality Compass to compare performance of Minnesota's populations with national and other states' performance.

The DHS Health Care Research and Quality Division will conduct this component of the waiver evaluation and review results over the second half of calendar year 2021, with the draft final report submitted to CMS in December 2021.

Below is an overview of evaluation activities and timelines:

August 2020: DHS will calculate measurement rates for baseline goals.
September-October 2020: DHS will calculate and stratify HEDIS 2015-2019 performance measures.
October 2021: HEDIS results will be reviewed and evaluated.
November-December 2021: Draft final waiver report is written, reviewed and submitted to CMS.
March 2022: CMS submits feedback to DHS.
May 2022: DHS incorporates CMS feedback. Final report is submitted to CMS.

Waiver Authority under Sections 5.3

The Minnesota Department of Health and DHS will conduct this component of the waiver evaluation. MERC Program data for the baseline period (DY 19 and DY 20) will be compiled and compared to CY 2016, 2017, 2018, 2019, and 2020. Medicaid provider enrollment data for CY 2016 through 2020 will be extracted and analyzed. The results will be incorporated into the draft final report.

ATTACHMENT C
HISTORICAL PMPM FOR THE PMAP + SECTION 1115 DEMONSTRATION

DY	SFY	Minnesota-Care Pregnant Women	Minnesota-Care Children	MA Children	Caretaker Adults	Minnesota-Care Adults without Children	Medicaid Caretaker adults living with 18 yr
1	1996	$532.85	$77.28	$480.34	$0		
2	1997	$550.96	$84.84	$516.00	$0		
3	1998	$780.63	$93.34	$534.46	$0		
4	1999	$808.73	$98.57	$563.86 - 1st 6 m $198.10 - 2nd 6 m	$135.46		
5	2000	$855.64	$105.82	$212.68	$143.32		
6	2001	$905.26	$113.61	$228.33	$151.63		
7	2002	$957.78	$121.97	$245.14	$160.42		
8	2003	$455.17	$152.97	$177.25	$294.62		
9	2004	$491.58	$164.23	$190.30	$318.19		
10	2005	$530.91	$176.32	$204.30	$343.64		
11	2006	$573.38	$189.30	$219.34	$371.13		
12	2007	$619.25	$203.23	$235.48	$400.82		
13	2008	$668.79	$218.19	$252.81	$432.89		
14	2009	$715.28	$233.35	$270.38	$462.98		
15	2010	$764.99	$249.56	$289.17	$495.16	$499.06	
16	2011	$818.15	$266.91	$309.27	$529.57	$530.00	
17	2012	$861.51	$280.00	$324.42	$557.64	$562.86	
18	2013	$907.17	$293.72	$340.32	$587.19	$597.76	
19	2014	$955.25	$308.11	$357.00	$618.31	$634.82	$487.00
20	2015	1005.88		$374.49			$512.81
21	2016	N/A		$389.10			$537.94